

# AMBULATORY SURGICAL CENTERS PAYMENT SYSTEM

payment**basics**

Since 1982, Medicare has covered surgical procedures provided in freestanding or hospital-based ambulatory surgical centers (ASCs). ASCs are distinct facilities that furnish only ambulatory surgery; the most common procedures are cataract removal and lens replacement, colonoscopy, and other eye procedures. Payments to ASCs (about \$2 billion in 2003), including both program and beneficiary spending, account for less than 1 percent of total Medicare spending.

Medicare pays for surgery-related facility services provided in ASCs—such as operative nursing, recovery care, anesthetics, drugs, and other supplies—using a simple fee schedule (Medicare pays for the related physician services—surgery and anesthesia—under the physician fee schedule.) The ASC fee schedule sets payment rates for nine procedure groups. The payment rates, which range from \$333 to \$1,339, are adjusted to reflect geographic differences in market input prices.

## Defining the care that Medicare buys

The unit of payment in the ASC payment system is the individual surgical procedure. Each of the over 2,400 procedures approved for payment in an ASC is classified into one of nine payment groups based only on their cost similarity, rather than clinical similarity.

Approved procedures generally are limited to those that are provided in hospital inpatient settings that also can be performed safely in outpatient facilities. Procedures frequently performed in physician offices are specifically excluded from ASC coverage. ASC-approved procedures generally require less than 90 minutes of operating room time and less than 4 hours of recovery room time and do

not require an overnight stay. The Centers for Medicare & Medicaid Services (CMS) is required to update the list of procedures approved for payment in ASCs every two years.

## Setting the payment rates

To set ASC payment rates, CMS previously was required to survey a sample of ASCs every five years to collect data on their costs and charges for individual procedures. After auditing the survey data, CMS adjusted ASCs' charges to reflect costs using cost-to-charge ratios. CMS set the national payment rate for each of the nine payment groups equal to the estimated median cost of procedures in that group (Figure 1). To account for geographic differences in market input prices, CMS adjusts the labor portion of the rate using the hospital wage index for the ASC's location. The labor portion of the rate is 34.45 percent.

ASC payment rates also are adjusted when multiple surgical procedures are performed during the same operative session. In this case, the ASC receives full payment only for the procedure with the highest payment rate; payments for the other procedures are reduced to one-half of their usual rates.

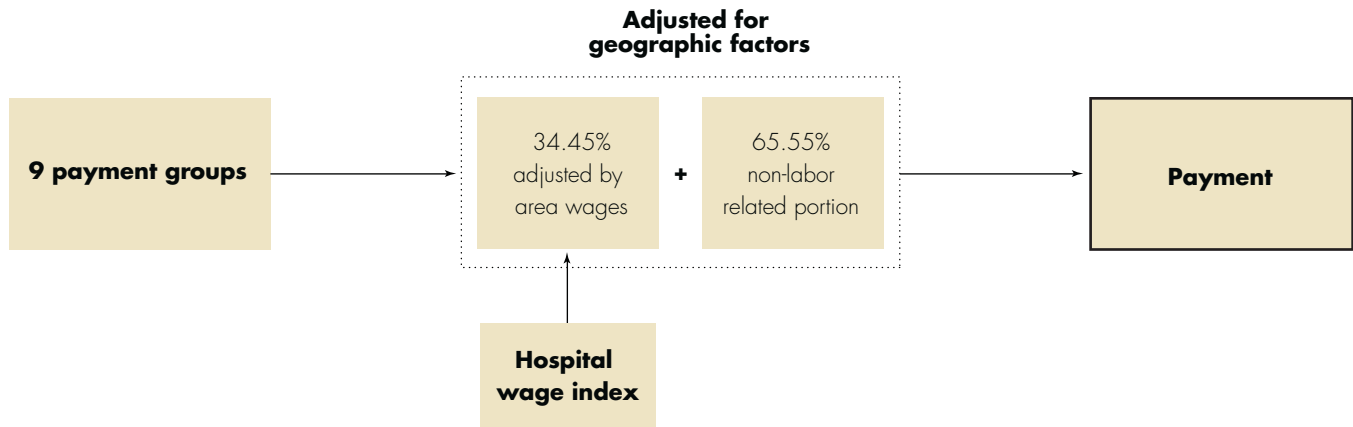
Between cost surveys, the ASC payment rates were updated annually based on the consumer price index for all urban consumers. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 contained many provisions that affect the ASC payment system. The law:

- Eliminated the payment update for ASC services for fiscal year 2005, changed the update cycle to a calendar year from a fiscal year, and eliminated the updates for calendar years 2006 through 2009;

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**Figure 1 Ambulatory surgical centers prospective payment system**



- Eliminated the provision that CMS survey ASCs' costs and charges every five years. It required the Government Accountability Office (GAO) to study the relative costs of services in ASCs and hospital outpatient departments and whether the outpatient prospective payment system's (PPS's) procedure groups reflect ASC procedures. Based on its study, which has not yet been completed, the GAO should recommend to CMS whether to use the outpatient PPS's procedure groups and relative payment weights as the basis for a revised ASC payment system; and
- Required the Secretary to implement a revised ASC payment system no earlier than January 2006 and no later than January 2008, taking into account the GAO's recommendations. Total payments under the new system should be equal to the total projected payments under the old system. ■